Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UHS OF TEXOMA

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-15-1439-01

Carrier's Austin Representative
Box Number: 45

MFDR Date Received
JANUARY 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am filing this MDR to appeal for appropriate payment on this claim and to preserve our rights. Insurance denied this bill for timely filing. Hospital system notes show that this was billed to carrier on 5/5/14-well within the timely filing limit. I have attached the hospital system notes for verification."

Amount in Dispute: $1,296.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor UHS of Texoma, the office performed an in-depth review of the requestor's billing and determined that we will maintain our denial of 29-Time limit for filing has expired. The Office received a complete medical bill for the date of service 4/1/2014-4/17/2014 on 10/15/2014 as indicated by the date stamp on the UB 04 in the amount of $3,534.52, an audit found that the bill was not timely filed pursuant to §Rule 133.20 (b) and issued a denial for 20-Time limit for filing has expired on 10/27/2014… The Division has been clear and consistent with prior medical fee dispute decision's that there are two forms of accepted evidence of timely filing which has historically been fax confirmation or certified mail receipt. The Office reviewed the requestor's dispute packet and was unable to locate sufficient evidence that their bills were 'sent' within 95 days from the date of service or evidence that the facility erroneously submitted their billing to an incorrect carrier, furthermore the Office reviewed the billing history for the above referenced claim and did not locate this provider's billing submission on or after the date of 5/5/2014 as stated in their position statement."

Response Submitted by: STATE OFFICE OF RISK MANAGEMENT

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2014 through April 17. 2014	Hospital Outpatient Physical Therapy	$1,296.59	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 119 – Benefit maximum for this time period or occurrence has been reached.
   - 257 – The frequency of this procedure exceeds the time limitation guideline.
   - 937 – Service(s) are denied based on HB& provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
   - 29 – This procedure is normally part of automated test panel five and is reimbursed under the appropriate panel code.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. This claim was process properly the first time.
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, "except as provided in Texas Labor Code §408.0272(b)(c) and (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds no convincing documentation to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 22, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.